

Abused women's experiences of a primary care identification and referral intervention

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Abused women's experiences of a primary care identification and referral intervention: A case study analysis

Abstract:

Aims: To report the findings of a qualitative case study that investigated abused women's experiences of an identification and referral intervention and to discuss the implications for nurses, specifically those working in primary and community care.

Background: Domestic violence and abuse is a significant public health issue globally but it is a hidden problem that is under-reported. In the UK, Identification and Referral to Improve Safety is a primary care-based intervention that has been found to increase referral rates of abused women to support and safety services. This paper reports on the findings of an evaluation study of two sites in England.

Design: Qualitative study with a case study design.

Methods: In line with case study design the entire evaluation study employed multiple data collection methods. We report on the qualitative interviews with women referred through the programme. The aim was to elicit their experiences of the three aspects of the intervention: identification; referral; safety. Data collection took place March 2016.

Findings: Ten women took part. Eight had exited the abusive relationship but two remained with the partner who had perpetrated the abuse. Women were overwhelmingly positive about the programme and irrespective of whether they had remained or exited the relationship all reported perceptions of increased safety and improved health.

Conclusion: Nurses have an important role to play in identifying domestic violence and abuse and in referral and safety planning. Interventions that empower women to take control of their safety (such as Identification and Referral to Improve Safety) are important.

Keywords: Abuse, Case study, Domestic Violence, Identification, Intimate Partner Violence, Nursing, Qualitative, Referral, Safety.

Summary Statement:

Why is this research needed?

- Domestic violence and abuse is a significant public health issue globally but it is a hidden problem that is underreported.
- Identification and Referral to Improve Safety is a primary care-based intervention in the UK that increases referral rates of abused women to support and safety services.
- Women's experiences of being referred through the programme have to date not been captured fully.

What are the key findings?

- Of the ten women who took part, eight had exited the abusive relationship while two remained with the perpetrator.

- Women's perceptions were that they were safer and healthier as a result of the intervention.
- Nurses have an important role to play in identifying domestic violence and abuse and in referral and safety planning.

How should the findings be used to influence policy/practice/research/education?

- Domestic violence and abuse interventions that empower women to take control of their safety are important.
- Perpetrator-targeted interventions on stopping abuse from happening are crucial.
- Future research could investigate the impact of domestic violence and abuse intervention in empowering women's self-care agency, as well as the longer-term impacts on women's health through longitudinal studies.

INTRODUCTION

Domestic violence and abuse (DVA) is fast becoming a public health emergency which costs lives and negatively impacts upon the long term health of individuals, families and communities (Warren-Gash et al. 2016). It is currently described by the World Health Organization (WHO) (2013) as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty. In the UK, DVA is taken to mean an incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Home Office 2013). **DVA includes honour based violence, early and forced marriage, and female genital mutilation. Importantly, it is ‘usually recurrent, happening to the same person at multiple times over the lifespan and is often passed from one generation to another’ (Reilly & Gravdal 2012, p. 333).**

The National Institute for Health and Care Excellence (NICE) (2014) has reported that over 1.2 million women and 750,000 men in England and Wales experience DVA. Population estimates for DVA prevalence in the UK range from 15%-71% (The Health Foundation 2011).

Both women and men can experience DVA but there are significant differences (in terms of the frequency and the nature of the abuse) between DVA experienced by men and women. For example, far more women than men are killed by partners/ex-partners and in 2013/14, this was 46% female homicides compared with 7% male (Office for National Statistics 2015). In her analysis of who does what to whom, Hester (2013) reported that men’s violence tends to create a context of fear and control, which is not the case when women are perpetrators and also, in cases where women are perpetrators, most (62%) have single events recorded compared to the multiple violations associated with male perpetrators. All these issues point to the highly gendered nature of DVA and it is recognised as such in our paper.

There is a well-recognised correlation between DVA and poor health among those who experience it directly. Additionally, children who live with DVA are affected in multiple ways (Humphreys et al. 2008). They are far more likely than other children to experience a range of detrimental impacts to their health including post-traumatic stress, depression and behavioural difficulties (Smith et al. 2014). Importantly, they are at elevated risk of being abused themselves (Coordinated Action Against Domestic Abuse 2014). Overall, DVA is a serious issue and one that has direct, negative impacts on the long-term health of all those who experience it.

DVA is evident across all sectors of society and the cultural and anticipated fear of social or psychological stigma is a significant feature of under-reporting (Overstreet & Quinn 2013). Sustained safety planning for women who do report DVA is essential (Hooker & Small 2016). This requires professional awareness and confidence in recognising the myriad ways in which DVA may present. Many health professionals and women report that they are aware of the physical and sexual aspects of abuse. However, some are less cognisant of other aspects of abuse, for example its impact on children (Taylor et al. 2013) or adolescents who experience dating violence (Burton et al. 2011, Lepisto et al. 2010).

Regarding confidence among health professionals in dealing with DVA, the landscape of evidence is varied. Reporting on findings from a study conducted in Iceland, Svavarsdottir and Orlygsdottir (2009) found that nurses working in emergency departments and midwives working in high risk prenatal care clinics were confident in translating DVA clinical guidelines into response actions. Similarly, a study conducted in Scotland found that some health visitors, midwives and General Practitioners (GPs) were confident in dealing with the issue (Bradbury-Jones et al. 2014a; Taylor et al. 2013). Importantly though, that study also

highlighted uncertainty in dealing with DVA among many health professionals who took part. Such findings are supported by research across different countries and clinical contexts. For example, in their USA study, Davidov and Jack (2014) found that nurse home visitors were unsure about their role in mandatory reporting of abuse against women and children. District nurses in primary health care in Sweden have been reported as hesitant and ambivalent in dealing with suspected DVA (Sundborg et al. 2015) and Yeung and colleagues (2012) reported that GPs and nurses working in primary care in the UK were often unaware of appropriate interventions and referral pathways. Overall, empirical evidence indicates that when a woman discloses DVA the health professional response has been habitually inadequate. The need for effective interventions to address this is unequivocal. The purpose of this paper is to report the findings of qualitative study conducted in the UK that evaluated women's experiences of a primary care intervention aimed at improving identification, referral and safety of women with DVA experiences. From our findings we explore the lessons for nursing practice.

BACKGROUND

In England where the evaluation study was undertaken, 'primary care' is the first point of contact for most people and is delivered by a wide range of independent contractors, including family doctors/ GPs, dentists, pharmacists, optometrists, NHS walk-in centres and NHS telephone services (NHS Choices 2016). Some nurses are employed within these settings, for example practice nurses, who work with GPs. Other nurses also work in close collaboration with GPs but commissioning arrangements are such that they are not employed by them, such as district nurses, health visitors, school nurses and children's community nurses. In this paper for simplicity we use the term 'nurses' to mean all those who work for or

with GPs in a primary care setting. The findings from our study have direct relevance to these groups of nurses.

Identification and Referral to Improve Safety (IRIS)

Between 6% and 23% of women attending a GP will have experienced physical or sexual abuse from their current or previous partner in the past year (The Health Foundation 2011). The Identification and Referral to Improve Safety (IRIS) programme was developed in response to this problem. An important issue regarding IRIS is that it is based on sound evidence regarding effectiveness. IRIS is a DVA training, support and referral programme for GP practices that has been evaluated in a randomised controlled trial (Feder et al. 2011). The trial took place in Hackney (London) and Bristol between 2007 and 2010, funded by The Health Foundation. The aim of the trial was to test the effectiveness of a programme of training and support in primary health care practices to increase identification of women experiencing DVA and their referral to advocacy services. Effectiveness was based on two outcomes: Referral of women to a DVA agency providing advocacy; Recording of disclosure of DVA in the patient's medical record.

Twelve GP practices in each site received the intervention and another 12 practices did not (the control). Women attending intervention practices were six times more likely to be referred to an advocate than those in the control group and three times more likely to have a recorded identification of DVA in their medical record (Feder et al. 2011). **IRIS was found to be an effective intervention.** Following the trial, The Health Foundation provided two years' further funding to implement IRIS in other areas of the UK. The IRIS programme entails a full-time advocate working with up to 25 GP practices. **It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS provides**

information and signposting for male victims and for perpetrators (IRIS 2016a) and the IRIS+ programme is currently being developed and tested to improve responses to children exposed to DVA and men experiencing or perpetrating DVA (details available: <http://www.bristol.ac.uk/primaryhealthcare/researchthemes/reprovide/>)

The IRIS training for GP practices is divided into administration and clinical training. It is organised thus:

‘The practice team receives in-house training and ongoing support. Clinician training focuses on identification of DVA through clinical enquiry and appropriate response, referral and recording. This includes assessing immediate risk and safety planning. Training for reception and administration teams focuses on understanding DVA, data handling, confidentiality and safety’. (IRIS 2016b)

Overall, the emphasis of IRIS is on recognising when a person may be experiencing DVA, knowing how to discuss the issue and crucially, having a direct line of referral through to an advocate who is often (although not necessarily) based in an organisation such as Women’s Aid. Post-referral, women are supported by the advocate and directed towards other services and help as needed. For more information on the IRIS service see <http://www.irisdomesticviolence.org.uk/iris/about-iris/iris-service/>. A national evaluation of IRIS is in progress and a number of local evaluations have also taken place. This paper arises from data gathered for the evaluation of two IRIS sites in England.

Recent analyses have shown that a great deal of qualitative research in health and social care is atheoretical (Bradbury-Jones et al. 2014b). We approached our investigation theoretically

with reference to the elements of the IRIS model: identification, referral and safety. Although not a theoretical framework as such, we used these three elements to give structure and form to the study, as reflected for example in the interview schedule (Table 1) and presentation of findings.

THE STUDY

Aim/s

The aim of the study was to evaluate how the IRIS programme had been implemented in two sites in England. The study questions were:

- 1) How has IRIS been implemented to fit local context and needs?
- 2) What are the opportunities and challenges associated with IRIS as stated by the providers of the service locally?
- 3) What are women's experiences of the identification and referral processes?
- 4) What impact has IRIS had on the perceived wellbeing and safety of women referred through the service?

The purpose of this paper is to report on the findings relating to questions 3 and 4. Findings from questions 1 and 2 have been provided in local evaluation reports.

Design

The evaluation study drew on a qualitative case study methodology described by Yin, which is an approach to inquiry that follows 'a rigorous methodological path' (Yin 2014, p.3). Case study focuses on people and programmes, each one being similar to other programmes, but unique in many ways. In a case study approach, evaluators and researchers are interested in 'uniqueness and commonality' (Stake 1995, p.1). In this study we were interested in how

the core programme of IRIS as detailed in the commissioning information (the commonality) has been implemented to meet the unique needs of two local sites (uniqueness).

Sample/Participants

A case study approach to evaluation uses multiple data sources (Baxter & Jack 2008). Data for the overall study evaluation included 1) Email questionnaires responses from IRIS sites; 2) Written feedback from IRIS practices; 3) IRIS documentation and archival records; 4) Individual interviews with women referred through IRIS. This paper is focused solely on the latter. We recruited a sample of women from two IRIS pilot sites in Birmingham, England. Access and recruitment of women was through the advocate at both evaluation sites.

The advocate identified potential participants from the database, selecting only those who were considered safe and well. The inclusion criteria were that all women had to be referred through the IRIS programme and they all needed to be emotionally and physically safe and well (as assessed by the primary gatekeepers – the advocate). Women were excluded if there was any concern about their wellbeing or safety. The advocate provided initial information about the study to women and gained consent for the principal investigator (*initials*) to make contact via a safe telephone number.

Data collection

For those who agreed to be interviewed, a convenient and safe location was identified. Of the 10 women who took part, one opted for the interview to take place at the GP surgery because this was a familiar setting. Four women were interviewed at Women's Aid offices (again because this was familiar and safe). The remaining participants were interviewed over the phone. Interviews were based around the questions and discussion points in the interview guide (Table 1). All interviews were audio recorded with the woman's consent.

{Table 1}

Ethical considerations

The University of [insert after review] Science, Technology, Engineering and Mathematics Ethical Review Committee approved the study (Reference ERN_15-1698). DVA research carries specific ethical challenges (Ellsberg & Heise 2002). Working on the ethical principle of ‘do no harm’, the fundamental basis of this study was to protect all those who contributed from potential harm. Consent was sought from women prior to taking part and their physical and emotional safety were critical. At any point of recruitment and/or data collection if there were indicators of risk (such as the presence of a partner), contact was deferred or terminated. Anonymity and confidentiality were assured and all potentially identifying material has been removed in this publication. Vicarious trauma can be a real issue in abuse research and there is potential for researchers to be upset by listening to participants’ accounts (Taylor et al. 2016). To address this the research team supported each other through regular meetings, reflexivity and care of each other.

Data analysis

Data analysis was undertaken using a thematic approach guided by the approach of Braun and Clark (2006). Data were analysed inductively and then mapped deductively to the three IRIS elements: Identification; Referral; Safety. Two authors (*initials*) undertook the initial analysis and then selected quotes as presented in this article were independently cross referenced to the entire data set by (*author*).

Rigour

We engaged with several processes to ensure the rigour of the study. Case study data were analysed using a team approach to ensure the thematic findings were consistent and agreed by all authors. Reflexivity is at the heart of qualitative research (Bradbury-Jones 2007) and our analytical processes comprised reflexive peer discussions about the women’s narratives of

abuse, which we acknowledged were sometimes inchoately presented. In line with the case study design, the aim of the study was to provide an in-depth understanding of the ‘case’ (Creswell 2013) as captured by the women who took part. We did not reduce or subject women’s narratives to coded fragments of conversation; instead we chose to honour the chaos of their experiences in the way they chose to present themselves at this transitional time of relationship upheaval and change in their lives.

Women’s perceptions of the level of risk they experienced were demonstrated through their narratives of abuse. This enabled insights into the patterns of disclosure and disclosure behaviours that resulted in referral. Conclusions were subsequently drawn as to the likely impact of IRIS, with attention to the relationship between risk, disclosure and women’s agency in negotiating their particular route to safety and wellbeing over time.

FINDINGS

Ten women were recruited (four from one site and six from the other). From our extensive experience in researching DVA we know that most women are highly reluctant to disclose personal details. Reflecting on the ethical considerations already described, our priority was on safety. For this reason minimal demographic data were collected (age and ethnicity only). The age profile of the women was 21-72 years, with their ethnicity status comprising White British (majority) as well as African, Afro-Caribbean, Pakistani and White European communities. We did not ask them for any more detail because of the perceived or actual safety risks. We have used pseudonyms for each woman. Data are presented around three themes: Identification, Referral, Safety – although there is some unavoidable and understandable overlap in the way that women talk about their experiences.

Identification

All women in the study reflected on the point at which they had presented at the GP practice, with most having taken decisive action to disclose at that point:

I was going through a lot of domestic violence from my husband who was beating me up and mentally torturing me... he was on the verge... he wanted to actually murder me... I went to my GP and told him what was happening and he referred me. Lena

Similarly:

Participant: The incident happened I think it was about six o'clock in the evening and I went to the surgery in the morning.

Interviewer: So did you go to your GP specifically to tell them about it or did it just come up in conversation?

Participant: I went in the doctor who saw me straight away and then I told her, I said this is what happened and stuff and she said 'we've got a domestic abuse advocate who is from our surgery and she's part of the domestic Women's Aid and she really helps, do you want me to put you through to her?' I said 'yes'.
Jemma

There were two examples where GPs had tuned into mental health issues and used this as a lever for asking about DVA:

I went to my GP and I explained my problems to her because I was experiencing domestic violence with my husband and I was depressed and stuff and on antidepressants and so my GP asked what was leading to my depression and I told her everything. She told me if I needed help they could call women's aid and they called up women's aid and made an appointment for me to see the advocate. Lauren

When I came to see the doctor I said that I wanted to come off the antidepressants and she said did I need some help and that she can refer me.
Misha

Responses to disclosure differed, with some women experiencing a degree of indifference from the GP:

Interviewer: When you told the GP, how did that feel? What was the response of your GP?

Participant: He didn't pay too much attention really... he gave me the leaflet and said these people can help. The GP only gets 10 minutes you know?

Interviewer: How happy were you with the response?

Participant: Neither here nor there really... Giving me the leaflet helped me.

Interviewer: Could the GP have done anything different?

Participant: I'm not sure, but maybe if he'd put me onto someone there and then... Patsy

Here Patsy conveys a sense of ambivalence about the actions of the GP however she does allude to the usefulness of a leaflet. We will discuss the action of giving a leaflet later.

Referral

Referral was a point of relief for all women in the study, with women valuing the fact that GPs took action:

My doctor referred me. She was absolutely unbelievable. She took it very seriously. At this point I had been to every service and no-one cared. At this point I was really down and I was homeless with the kids. And I just thought 'someone is going to help me now'. Eisha

She (GP) is the one who contacted women's aid, I don't know how she did it, but she did it and she said 'someone from women's aid will call you'. Lauren

Amidst the largely positive experiences of women regarding GP's actions, one woman was disappointed that her GP did not provide her with post-referral follow-up:

My GP should have contacted me to see if everything was alright and to be honest I'm not really happy... I would have liked them to contact me, even to ring me up to see how things are going on. How things are at home. They don't know what's going on with me, so I'm not very happy to be honest. Jemma

Overall though, women reported the significant value of having contact with the advocate:

She (advocate) was the one who helped. When I said I wanted to leave she was the one who took me to the house and waited for me to get my things while my husband was out. She waited for me in the car...then she took me to somewhere safe...Lauren

She (advocate) came out to see me. To be honest she gave me all the information. She gave me all the choices. She gave me options as well and said you don't have to go ahead with anything. I was really happy with her to

be honest. She was really helpful. She listened to me and gave me advice and I am really pleased with her. Clara

I had no income no benefits and bless her, she put me onto the welfare and they helped me sort the paperwork. She has been a real life saver. Lena

Referral does not always equate to a woman leaving her relationship, but IRIS provides a perception of safety for those women who stay in a relationship:

Participant: Things are better now and my husband is getting help too. He is booked on courses.

Interviewer: So he is getting help too?

Participant: Yes.

Interviewer: Are you still with your husband?

Participant: Yes, but I know what to do if it happens again - how to be safe... I don't have to be scared. Bahia

We have already reported the value that Patsy found in being provided with a leaflet. Here we expand on her account and show the leaflet's value in supporting her agency and shaping her action at a point of readiness:

Participant: I went to the doctors and they gave me a leaflet. They didn't refer me they gave me a leaflet.

Interviewer: Did they offer you anything else?

Participant: Not really... I made the referral myself

Interviewer: What was the time difference between you being given the leaflet and making the call?

Participant: A long while. It got worse and worse and I picked up that bit of paper. Once I got that leaflet I was too scared to call. I couldn't do it and then one day it overcame me and I thought 'I have to do something'

Interviewer: And you had kept that leaflet tucked away?

Participant: Yes and then I made the call. Patsy

Safety

Women's perception of safety following referral through the programme was clear:

I got a lot of information that I needed because I was going through the services for the first time because I am not from Britain and so I got advice about the services so that I could use them in the future. So I know for the future and I was learning about what to do if it happened again. I just needed to know what to do in an emergency so I felt safer knowing there is help. Bahia

It's made me more confident... it's helped me learn about different types of abuse... My biggest happiness is that I can go home and be safe. I feel safe and [advocate] has helped with everything with that. Lena

After seeing [advocate] a few times I must say she made me look at myself in a different way, in that I have rights like anyone else... now I can say that I'm not putting up with this because I have someone on my side, so in a sense I feel a lot better in how I deal with it. Misha

The educational programmes offered by Women's Aid were helpful for some women:

[The advocate] kept saying 'come [to the course] it'll do you good. You don't have to come, but it will do you good'. [So I went] and it is like an extra part of your family, it feels like you can come here and if you've got a problem they can one way or another try and help you sort it out or signpost you to where you can go. They have the information and it's just so amazing, you know? I just feel so comfortable. She [advocate] gave me options. So they gave you choices where you feel in control. They give you choices. Eisha

Participant: At first I was like scared to come because a group of people talking in front of, but then when I just kept coming after a bit I got used to it and then found it was very good.

Interviewer: What kind of things do you cover [learn] on that?

Participant: Like 'the bad father', 'the bully', 'the jailer', 'sexual controller', 'the head worker', 'the king of the castle'... and some other stuff... it's changed my confidence a lot. And it's helped me realise the kind of different abusive relationships you can like get, so it has helped me a lot with that. Sonia

Women did not feel judged and felt they were in charge of the choices they were given. This is evident in Eisha's account and Jemma also talked about the importance of choice:

To be honest she [advocate] was really helpful... she gave me time to think, talked to me about everything. The options and what I want to do [she said] 'whatever you want to do it is your choice and there's no pressure' Jemma

Earlier we reported how Lena had referred to her advocate as a 'life saver'. This was not mere metaphor. There was a fundamental belief amongst women that without IRIS and the subsequent help they received they may well have been dead; captured poignantly in this concluding quote:

They would have been taking me out in a box by now... they have shown me light at the end the tunnel and all I have to do is walk towards the light and hold my hand out and if I fall they will help me get up. Eisha

DISCUSSION

The Health Foundation (2011) reported that UK health services have a notably poor record when it comes to identification and handling of DVA. Similarly, in our previous research we found that some nurses lacked confidence in dealing with the DVA (Bradbury-Jones et al. 2014a). Other authors have reported similar issues, with health professionals (including nurses), appearing to lack empathy and sensitivity (Reisenhofer & Seibold 2012) and to seem uncaring (Ormon et al. 2013) when dealing with abused women. There are increasing efforts to find out why this is the case (Bradbury-Jones, Appleton & Watts 2016). One important reason may be that nurses find the issue of DVA difficult personally, with a disproportionate amount of them experiencing abuse themselves (Cavell Nurses' Trust 2016). In this context, it is important to support, rather than blame nurses when at times they make lack capacity to support others.

Regarding the current study, the impact of IRIS is such that women spoke of their GPs confidently, actively and purposefully asking about the root causes of their depression, with potential linkages to DVA. This ‘digging deep’ is important and may be attributed to GPs’ increased understandings about the relationships between poor mental health and DVA. This is positive progress because studies have found that GPs are sometimes quick to prescribe antidepressants without enquiring about abuse as a potential associated factor (Taylor et al. 2013). A key message for nurses is to similarly dig deep. In their holistic assessments, nurses are reminded to consider the multiplicity of issues with which many patients present and keep in mind the potential association between these and DVA.

In this study, some participants had been given leaflets by GPs as the source of information. Patsy had carried her leaflet around for a long time until she was ready to take decisive action. A message here –for nurses and GPs – is that even if the only action is the giving of a leaflet, this too can have an impact. Readiness to leave is a complicated issue and providing information can make a difference. Overall, most women were positive about their GP’s responses and handling of the disclosure event although as highlighted by one participant (Jemma), post-referral support and follow-up are important. Nurses can have a role here in reaching out to women following referral and in so doing, show interest and concern for their safety and well-being.

IRIS adds value to our understanding of organisational perceptions of risk, and women’s exercising of agency in their disclosure of abuse to nurses or GPs. In Patsy’s case at least, her decision to report abuse through IRIS is an *a priori* aspect of her help seeking, representing a longer trajectory of information gathering and disclosure. Commonly, disclosure of abuse is prompted by a new crisis event (such as escalating abuse) and women seek help when they have experienced a turning point in their experience of abuse, which impacts upon their sense

of personal or family safety. Seeking professional help at a time of crisis supports the self-care movement from contemplation about the experience of abuse, to personal action in making some attempt to stop the abuse, supporting common health behaviour change theories, such as that of Prochaska (2008). Nurses need to be equipped to respond confidently and appropriately at this point of help-seeking.

Our analysis indicates that women's disclosure demonstrates their movement towards safety and self-preservation; women seem to use a combination of planned or reasoned action, supported by their social learning about abuse in the IRIS context. Daniel (2010) offers the reminder that once the abuse is named, health professionals have to deal with and accept uncertainty regarding when and how women choose to stay in, or leave, their abusive relationship. Some women leave but may return, or move on - still connected to their abuser and/or enmeshed in cycles of co-dependence. Whether they leave, separate, or stay, this can involve women's continued risk-taking/behaviour at home. Nonetheless, nurses can acknowledge women's agency even when remaining in a relationship with or separating from the abuser. In our study, women's narrative accounts demonstrated a degree of self-efficacy and resilience (perhaps) in the way that the timing of their disclosure related to response to a real risk event. Through IRIS, and supporting Lupton's (1999) 'realist' perspective of risk, DVA is rendered an objectively negotiated hazard, measured independently of social and cultural processes, but possibly influenced through social and cultural frames of interpretation.

Previous studies have reported on the importance of short courses on understanding DVA for women after exiting a relationship (Kelly et al. 2014). We found this in our study too, with women reporting the benefits of learning about strategies for safety planning. They

emphasised that they had been given choice about attending and could dip in and out of the service. In effect, this created a 'basket of resources' fitted to their individual needs (Kelly et al. 2014).

All women in our study reported that they felt empowered by the process of being referred through IRIS. Whilst not all chose to leave the abusive relationship, they nonetheless felt better equipped to deal with the future. Control and empowerment are important for people who have experienced DVA (Bradbury-Jones et al. 2016). Many have been stripped of all control and have borne the brunt of another's controlling behaviours. An important finding therefore is the strong sense of control that women experience as part of the IRIS programme. Nurses can reinforce this and provide optimal support through being cognisant of the detrimental impact that DVA has on women's self-esteem. Through empathy and support, nurses have a critical role in showing positive regard for women and their choices – whatever these may be.

Limitations

There are four principal limitations. Sample size is a complex issue in qualitative studies and there is no formula to calculate sample size in advance. Guest *et al.* (2016) found that data saturation is likely to occur within the first 12 interviews if there is homogeneity in the sample. We included only 10 women which falls a little short, but the sample was homogeneous regarding women's geographic location and abusive experiences. On balance we feel that the women's accounts were sufficiently rich to allow us to answer the research questions. The second limitation relates to data generation; the women were interviewed using different modes of communication – face-to-face and telephone interviews. However,

we prioritised women's safety and wanted to give voice to their experiences through whatever means were appropriate.

Thirdly, there are limits to theorising about the relationship between IRIS and women's agency in disclosing abuse. In identifying women's agency in an abusive situation there is a risk of neglecting the socio-political structures that significantly limit the capacity of some women to exit their relationship. For example, the organisational, community and family culture in which women live out their intention to leave an abusive relationship, may clash, collide or compound the abuse - abusive disempowerment in one area of life may impact upon another (such as social anxiety, and exclusion at work, leisure or home).

Finally, over-claiming needs to be avoided. Transferability of findings from this local evaluation study to other settings needs to be undertaken cautiously and critically. However despite inherent limitations, the study has provided important insights into the subjective experiences of women referred through the IRIS programme and the impact that it had on their wellbeing and safety.

CONCLUSION

We aligned this qualitative investigation to the three elements of the IRIS programme and we found this invaluable in eliciting women's experiences of identification of abuse, the referral processes and the perceived impact of IRIS on their safety. Women gave clear accounts of how it had impacted positively on their lives. Women's vulnerability had prompted their help-seeking agency and their self-care intention had enabled them to identify and use the support available to them. However, responsibility should not be solely on women keeping themselves safe. Perpetrator-targeted interventions on stopping abuse from happening are

crucial. That said, as part of an overall portfolio of DVA interventions, those that empower women to take control of their safety are important.

In the short term, it is clear that IRIS is a helpful organisational structure that shifts the primary care culture of communication. However, the longitudinal study by Kelly et al. (2014) included one hundred women, interviewed over a three year period. As they point out, there are long journeys towards freedom and lives are not rebuilt straight away. Future longitudinal studies are therefore needed to investigate the long-term impacts of interventions such as IRIS on women's self-care agency in securing their safety and wellbeing.

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